

**U.S. Department of Labor**

Office of Administrative Law Judges  
Seven Parkway Center - Room 290  
Pittsburgh, PA 15220

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**Issue date: 29Nov2001**

CASE NO.: 2001-BLA-444

In the Matter of:

DALE K. MILLER  
Claimant

v.

P.B.S. COALS, INC.  
Employer

and

ROXCOAL, INC.  
Employer

and

ROCKWOOD INSURANCE COMPANY  
Carrier

and

DIRECTOR, OFFICE OF WORKERS'  
COMPENSATION PROGRAMS  
Party in Interest

Appearances:

Jon A. Barkman, Esquire  
For the Claimant

Sean B. Epstein, Esquire  
For the Employer

Before: ROBERT J. LESNICK  
Administrative Law Judge

### **DECISION AND ORDER - DENYING BENEFITS**

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 et. seq. In accordance with the Act and the pertinent regulations, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs for a formal hearing.

Benefits under the Act are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis or to the survivors of persons whose death was caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lungs arising from coal mine employment and is commonly known as black lung.

A hearing was conducted in Pittsburgh, Pennsylvania on August 8, 2001 at which time all parties were afforded a full opportunity to present evidence and argument, as provided in the Act and the Regulations issued thereunder, found in Title 20, Code of Federal Regulations. During the hearing Director's Exhibits Nos. 1 through 31, Employer's Exhibit No. 1<sup>1</sup>, and Claimant's Exhibit No. 1 were received in evidence.<sup>2</sup> All of this evidence has been made part of the record.

### **ISSUES**

- 1.) Whether Claimant suffers from coal workers' pneumoconiosis
- 2.) Whether Claimant's pneumoconiosis arose out of coal mine employment.
- 3.) Whether Claimant is totally disabled.
- 4.) Whether Claimant's total disability is due to pneumoconiosis.

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<sup>1</sup> It was agreed at the time of the hearing that Employer's Exhibit No. 1, the deposition testimony of Dr. Mitchell Patti would be taken and submitted post-hearing. Therefore, the exhibit has been admitted to the record in this claim.

<sup>2</sup> The following abbreviations have been used in this opinion: DX = Director's exhibits; EX = Employer's exhibits; Claimant's Exhibits = CX; TR = Hearing Transcript; NR = Not recorded; BCR = Board-certified radiologist; B = B reader; A = A reader.

## **FINDINGS OF FACT AND CONCLUSIONS OF LAW**

### **Procedural History and Factual Background**

Dale K. Miller (“claimant” or “miner”) filed this claim for benefits under the Act on January 7, 2000. (DX 1). P.B.S. Coal (“employer”) was notified of the present claim for benefits on January 11, 2000 and filed a timely controversion on January 19, 2000. (DX 13 & 14). The claim was denied by the Office of Workers’ Compensation Programs on April 27, 2000, because claimant failed to establish that he suffers from totally disabling coal workers’ pneumoconiosis arising out of coal mine employment. (DX 16). On May 3, 2000, claimant requested a formal hearing before the Office of Administrative Law Judges (“OALJ”). (DX 16). The claim was referred to the OALJ on February 7, 2001. (DX 31).

Claimant filed a claim with the Bureau of Workmens’ Compensation for the Commonwealth of Pennsylvania. (DX 4). However, the claim with the Commonwealth of Pennsylvania was not related to pneumoconiosis or any other chronic lung disease. (DX 4).

The claimant testified at the August 8, 2001 hearing that he began his coal mine employment with Solar Fuel Company. (TR 12). Claimant worked for Solar Fuel Company for 14 to 15 years until he was laid off in 1983. (TR 12 & 20). From 1983 through 1986, claimant worked in coal mine employment with companies that he described as being small, family owned businesses. (TR 12 & 20). Claimant then went to work for employer and remained employed until for approximately 10 years until 1997. (TR 12). Claimant testified that all of his coal mine employment was underground and that he started as a laborer and eventually became a roof bolter. (TR 12). Claimant has not been employed since leaving the coal mine. (TR 15).

Claimant ceased to work in the coal mine industry in 1997 because he could no longer perform the “hard work” that his job entailed. (TR 12). Claimant stated that at the time that he quit working, he was experiencing difficulty breathing due to the amount of walking that the job required in addition to the heavy manual labor. (TR 12). Claimant explained that he was able to walk 1/4 of a mile before having to stop and that he wore a respirator while working, but that the respirator did not help his breathing problems. (TR 13). Claimant testified that he was also unable to place “crossbars on the roof.” (TR 13). Claimant stated that it would take two men to lift the crossbars. (TR 13). Claimant testified that he experienced difficulty breathing when attempting to lift the crossbars which required him to receive help from other miners. (TR 13).

Claimant testified that he uses a “puffer,” prescribed by his family physician, twice per day for his breathing difficulties. (TR 14). Claimant continues to experience difficulty breathing that had worsened since ceasing his coal mine employment. (TR 14 & 16). Additionally, claimant experiences wheezing and a yellowish productive cough. (TR 14). Claimant’s condition worsens when exposed to hot and humid weather conditions. (TR 15).

Claimant testified to his cigarette smoking history. Claimant was not clear on exactly how long he smoked cigarettes, but he did not believe that it was 27 years. (TR 17). Claimant ceased his cigarette smoking habit in 1999. (TR 17). Claimant stated that he never smoked more than 1/2 pack of cigarettes per day when he did smoke. (TR 18). Claimant testified that he “chewed snuff” more often than he smoked and that he would smoke “a little once in a while.” (TR 19).

Claimant stated that his claim pending in the Commonwealth of Pennsylvania had been denied. (TR 19). Claimant is treated for his breathing difficulties by his family physician, Dr. Kenneth Van Antwerp. (TR 20). Claimant has been married to his wife, Dorothy, for 44 years. (TR 11).

### Medical Evidence

#### Chest X-Rays<sup>3</sup>

<i><b>Exhibit No.</b></i>	<i><b>Date of X-ray</b></i>	<i><b>Date of Reading</b></i>	<i><b>Physician/ Qualifications</b></i>	<i><b>Interpretation</b></i>
EX 1	8-22-00	NR	Patti, BCPD <sup>4</sup>	Negative
DX 23	7-26-00	NR	Fino, B	1/1
DX 20	1-18-00	6-30-00	Soble, BCR/B	0/1
DX 20	1-18-00	6-30-00	Duncan, BCR/B	0/1
DX 20	1-18-00	7-5-00	Laucks, BCR/B	0/1
DX 12	1-18-00	2-10-00	Barrett, BCR/B	Negative
DX 11 & 22	1-18-00	1-18-00	Stankiewicz, BCR/A	Mild CWP
DX 23	11-12-99	NR	Fino, B	1/1

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<sup>3</sup> There are numerous diagnostic tests mentioned in the physician opinion reports in this claim. However, in mentioning these tests, all of the values necessary to determine the applicability of the regulatory provisions are not provided. Therefore, the diagnostic tests will be examined in the physician opinion section of this decision and the relevance of those tests will also be discussed at that time.

<sup>4</sup> Dr. Patti is board certified in pulmonary disease, however, he is not a board certified radiologist, nor is he a certified B-reader.

DX 22	11-12-99	NR	Malhorta, BCIM <sup>5</sup>	1/0
DX 22	11-12-99	11-12-99	Stankiewicz, BCR/A	COPD
DX 23	9-30-96	NR	Fino, B	1/1
DX 22	9-30-96	9-30-96	Stankiewicz, BCR/A	1/0

#### Pulmonary Function Studies

<i>Ex. No.</i>	<i>Date</i>	<i>Age</i>	<i>Height</i>	<i>FEV1</i>	<i>MVV</i>	<i>FVC</i>	<i>Tracings</i>	<i>Qualify</i>
DX 7	1-18-00	62	70	2.89	96	3.89	Yes	No
DX 22	12-10-99	62	NR	2.68	94	3.43	No	No

For a miner of Claimant's height of 70<sup>6</sup> inches, § 718.204 (c)(1) requires an FEV1 equal to or less than 2.03 for a male of 62 years of age. If such a FEV1 value is shown, there must be in addition, an FVC equal to or less than 2.59; or a MVV equal to or less than 81 or a ratio equal to or less than 55% when the results of the FEV1 tests are divided by the results of the FVC test.

#### Arterial Blood Gas Tests

<i>Exhibit No.</i>	<i>Date</i>	<i>pO2</i>	<i>pCO2</i>	<i>Qualify</i>
DX 10 & 22	1-18-00	74 78* <sup>7</sup>	35 36*	No

#### Physician Reports

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<sup>5</sup> Dr. Malhorta is board certified in internal medicine, however, he is not a board certified radiologist, nor is he a certified B-reader.

<sup>6</sup> The fact finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in this claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). In this case, only one of the pulmonary function studies records a height for Mr. Miller. Therefore I find that claimant is 70 inches tall.

<sup>7</sup> The \* indicates that the results are post-exercise.

*Dr. Kenneth Van Antwerp*

Dr. Kenneth Van Antwerp rendered an opinion in this claim on January 22, 2000. (DX 8). Dr. Van Antwerp is board certified in family practice.<sup>8</sup> Dr. Van Antwerp noted that claimant complained of attacks of wheezing for the prior 8 years, heart disease in the six months prior to the examination, and high blood pressure for 3 years. Dr. Van Antwerp also noted that claimant experienced reflux esophagitis. Claimant underwent a heart catheterization 6 months prior to Dr. Van Antwerp's report for "mild coronary artery disease."

Dr. Van Antwerp indicated that claimant had started smoking 10 years ago and had quite in the prior 6 months. Claimant stated to Dr. Van Antwerp that he smoked cigarettes "a little bit." Dr. Van Antwerp noted that claimant "chews snuff." Claimant complained of daily sputum, daily wheezing, dyspnea for 8 years, and an occasional cough. Dr. Van Antwerp noted that a chest x-ray, a pulmonary function study, and an arterial blood gas test were all completed on January 18, 2000. Dr. Van Antwerp diagnosed claimant as suffering from a history of hypertension and coronary artery disease. Dr. Van Antwerp did not find that claimant suffers from pneumoconiosis.

*Dr. Mitchell James Patti*

Dr. Mitchell James Patti issued a report in this claim on December 28, 2000. (DX 9). Dr. Patti is board certified in internal medicine and pulmonary disease. He is also a clinical assistant professor of medicine at the University of Pittsburgh Medical Center. Dr. Patti is the Director of Respiratory Therapy and Associate Director of Intensive Care at UPMC St. Margaret. (DX 9). Dr. Patti indicated that he evaluated claimant for exertional shortness of breath for 3 to 5 years prior to the examination.

Claimant reported his symptoms to include shortness of breath when walking more than 1/4 mile or climbing 2 flights of stairs. Claimant also stated that he experiences episodic wheezing, mucous production, and "expectorates mild amounts of yellow-white secretions every day." Claimant reported that he experiences occasional chest tightness and had undergone a cardiac catheterization. Dr. Patti noted claimant's cigarette smoking history to include 1/2 pack per day for 19 years. Dr. Patti indicated that claimant worked in coal mine employment for 24 years as a roof bolter. Claimant indicated to Dr. Patti that he wore a respirator at all times while working in the coal mine. Dr. Patti also noted that claimant had gained 75 pounds since he left his coal mine employment.

Dr. Patti noted that claimant's past medical history included mild coronary artery disease, hypertension, and obesity. Upon physical examination, claimant's chest was symmetric with normal

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<sup>8</sup> I take official notice of Dr. Van Antwerp's credentials from the American Board of Medical Specialties.

expansion. Dr. Patti noted no “accessory muscle use or intercostal retraction. The lungs are clear to auscultation. No areas of dullness to percussion. No abnormal change in tactile fremitus.” Dr. Patti ordered a chest x-ray of claimant that was interpreted by Dr. Fielding as showing no pulmonary infiltrates or masses. Dr. Patti also reviewed Dr. Malhorta’s report regarding claimant and claimant 1996 and 1999 arterial blood gas tests.

Dr. Patti stated that Dr. Malhorta’s pulmonary function study showed a decreased FEF 25/75 level. Dr. Patti said this value is not significant because the value is used to predict future lung impairment in smokers, but has no significance when evaluating for pneumoconiosis. Dr. Patti also stated that the MVV value has little significance in determining pulmonary impairment especially where all of the person’s other values are within the normal range. Because claimant’s pulmonary function study results were normal, Dr. Patti opines that Dr. Malhorta’s finding of disability is not well supported.

Dr. Patti found that claimant exhibited subjective complaints of shortness of breath. Dr. Patti found that claimant’s pulmonary function study showed no evidence of restrictive lung disease and his arterial blood gas test was normal. Dr. Patti concluded that claimant is not disabled due to pneumoconiosis. Dr. Patti found claimant’s shortness of breath to be caused by obesity and deconditioning. Dr. Patti reaches this conclusion based on the fact that claimant’s pulmonary function study was normal, the results of chest x-ray, and “normal augmentation of arterial oxygenation with exercise.” Dr. Patti found that all of these factors do not support a finding of pneumoconiosis nor significant coronary pulmonary disease.

Dr. Patti was also deposed in connection with this claim on August 17, 2001. (EX 1). Dr. Patti stated that his practice involves pulmonary medicine and critical care. Dr. Patti evaluates and treats patients who suffer from various pulmonary diseases. Dr. Patti stated that it is a regular part of his practice to evaluate persons who suffer from or are suspected to suffer from coal workers’ pneumoconiosis and the resulting pulmonary impairment.

Dr. Patti noted that claimant presented on August 22, 2000 with the chief complaint of shortness of breath. Dr. Patti reiterated the symptoms that he laid out in his written report. Dr. Patti explained that claimant’s prior heart problems are important to the evaluation because claimant’s shortness of breath could be related to this condition.

Dr. Patti discussed the fact that claimant had gained 74 pounds since the time that he left his coal mining job. Dr. Patti explained that patients who are overweight will exhibit shortness of breath and deconditioning because they gain more weight without exercising. As one does less exercise, the muscle function becomes less efficient. Dr. Patti explained further that obesity can cause a change in a patient’s pulmonary function that manifests in a decrease in the FVC value and diminished diffusion capacity.

Dr. Patti agreed that claimant was exposed to coal dust for over 20 years and that such exposure could lead to the development of coal workers' pneumoconiosis in a susceptible person. Dr. Patti then discussed claimant's smoking history that Dr. Patti believes is insufficient to expect signs of clinically significant chronic obstructive pulmonary disease.

Dr. Patti determined that claimant's physical examination showed normal vital signs, moderate obesity, clear lungs, no abnormal breath sounds, and normal heart sounds. Dr. Patti reviewed an August 22, 2000 chest x-ray that he found to show no signs of pneumoconiosis. Dr. Patti also found claimant's pulmonary function study results to be normal. Dr. Patti noted that claimant's lung volume results were normal. Dr. Patti points out that lung volumes are the most accurate way to determine the existence of restrictive lung disease. Dr. Patti found no evidence of any restrictive or obstructive pulmonary impairment. Dr. Patti interpreted claimant's arterial blood gas tests to show no evidence of pneumoconiosis.

The only abnormality that Dr. Patti found in claimant's pulmonary function study and lung volume test was consistent obesity. Dr. Patti found that based on claimant's diagnostic testing that claimant showed "no signs of restrictive lung disease or in fact any lung disease that could be attributed to coal workers' pneumoconiosis." Dr. Patti concluded that based on his evaluation of claimant and claimant's medical records that he would not consider claimant to be disabled from performing any of his previous work duties. Dr. Patti found no reason to restrict claimant's coal mine employment. Dr. Patti concluded that claimant shows no evidence of any lung disability related to coal dust exposure.

*Dr. Vijay K. Malhorta*

Dr. Vijay K. Malhorta issued a report in this claim on December 10, 1999. (DX 22). Dr. Malhorta is board certified in internal medicine. (CX 1). Dr. Malhorta noted that claimant had been employed in the coal mining industry for 28 years, all underground, which ended in April, 1996. While employed in the coal mining industry, claimant worked as a roof bolter. Dr. Malhorta described claimant's coal mining job as being "dusty and hard." Claimant's chief complaint at the time of the evaluation was shortness of breath for the 7 years prior to the examination date with progressive worsening of the condition.

Claimant told Dr. Malhorta that he was able to only walk 2 blocks at a slow pace, climb ten steps and walk 500 feet uphill before experiencing shortness of breath. Claimant also stated that he was experiencing a yellowish phlegm productive cough. Claimant stated that he required 2 pillows to sleep. Claimant's condition worsens with hot, humid weather. Claimant had undergone a heart catheterization one year before the evaluation for minimal blockage. Dr. Malhorta noted claimant's smoking history as including smoking 5 cigarettes per day for 19 to 20 years.

Upon physical examination, Dr. Malhorta found claimant's chest to be symmetrical with a few expiratory rhonci bilaterally. Dr. Malhorta ordered a chest x-ray that was interpreted by Dr. Stankiewicz. Dr. Malhorta found that the chest x-ray showed chronic obstructive pulmonary disease and an ILO classification of 1/0. Dr. Malhorta also ordered a pulmonary function study that was interpreted to show a mild reduction in the MVV indicating mild small airway disease.

Dr. Malhorta found that as "a result of his exposure to the elements of coal dust he has developed a pulmonary condition called pneumoconiosis. In my professional opinion he is disabled from his pulmonary condition totally and permanently from performing those jobs he did as a coal miner or labor or similar nature." In reaching this conclusion, Dr. Malhorta considered claimant's work history, pulmonary symptoms, the abnormalities on physical examination, the chest x-ray and pulmonary function study.

Dr. Malhorta was deposed in connection with this claim on May 4, 2000. (DX 22). Dr. Malhorta gained experience in treating coal miners when he was treating patients in England in the 1970s. Additionally, Dr. Malhorta has been conducting black lung evaluations for 14 years. Dr. Malhorta is a member of the faculty at Conemaugh Hospital.

Dr. Malhorta examined claimant on two separate occasions. Dr. Malhorta first examined claimant in 1996. At that time, Dr. Malhorta found radiographic evidence of coal workers' pneumoconiosis with a profusion of 1/0. However, claimant's pulmonary function study was within the normal range, and Dr. Malhorta found that claimant was not disabled by the disease. Dr. Malhorta advised claimant to revisit him for re-evaluation in 1 to 1.5 years.

Dr. Malhorta examined claimant again on November 12, 1999. At that time, claimant indicated to Dr. Malhorta that he was experiencing shortness of breath and had been for 7 years with progressive worsening. Upon physical examination, Dr. Malhorta noted that claimant was experiencing shortness of breath and coughing. Dr. Malhorta opined that claimant was breathing rapidly to compensate for his lack of oxygen. Claimant's chest expansion was approximately 2 inches. Dr. Malhorta noted that claimant's lungs exhibited rhonci on both sides. Dr. Malhorta opined that the rhonci indicate that claimant is having trouble expelling air from his lungs.

Dr. Malhorta conducted an EKG, chest x-ray, and pulmonary function study. Dr. Malhorta compared claimant's November 12, 1999 chest x-ray to the one that had been ordered in 1996. Dr. Malhorta found that the 1999 chest x-ray showed the rounded opacities that are indicative of coal workers' pneumoconiosis, with a profusion of 1/0. Dr. Malhorta also noted that claimant's lungs exhibit some hyperinflation with chronic obstructive pulmonary disease. Dr. Malhorta concluded that claimant's 1999 chest x-ray findings showed a worsening of claimant's condition.

Dr. Malhorta also conducted a pulmonary function study as a part of his examination. Dr. Malhorta noted that claimant's MVV value was only 50% of the predicted normal. Dr. Malhorta cites the significance of this value to be the MVV is the most sensitive predictor for a person's work capabilities. Dr. Malhorta opined that claimant's MVV value indicates that claimant suffers from obstructive lung disease. Dr. Malhorta interpreted the overall pulmonary function study results to show mild small airway disease and a reduction in MVV, which indicates disabling pneumoconiosis.

Dr. Malhorta bases his opinion on claimant's chest x-ray, physical examination, and pulmonary function study. Additionally, Dr. Malhorta notes claimant's 28 years of coal mine employment. Dr. Malhorta concluded that claimant developed pneumoconiosis secondary to coal dust exposure. Based on claimant's pulmonary function study results, Dr. Malhorta determined that claimant is disabled from performing his job as a roof bolter. Dr. Malhorta opined that claimant suffers from disabling coal workers' pneumoconiosis that arose out of claimant's coal mine employment.

Dr. Malhorta explained that pneumoconiosis is a form of pulmonary fibrosis. Dr. Malhorta further explained that a coal particle is taken into the lung and causes a "little irritation at the lung site and causes a reaction where the white blood cells from the blood vessels in the lung starts irritating that area of the lung and the normal body response to any irritation in the body is to lay fibrosis." This is what Dr. Malhorta opines occurred in claimant's lungs.

Dr. Malhorta took issue with Dr. Fino's report where Dr. Fino stated that claimant could work in a dusty environment provided that claimant uses a respirator. Dr. Malhorta indicated that no respirator will filter all of the dust particles and therefore may lead to further irritation of claimant's lungs. Dr. Malhorta interpreted Dr. Fino's comments to mean that claimant's condition would worsen if exposed to any further coal dust. Dr. Malhorta would agree with that statement. Dr. Malhorta believes that claimant is capable of performing sedentary work in a "very controlled environment" with "no excessive exposure to heat or dust."

Dr. Malhorta stated that he did not have access to the records of claimant's treating physician regarding claimant heart disease. Claimant had undergone a cardiac catheterization that showed mild deteriorative disease. Dr. Malhorta indicated that he had examined claimant on two separate occasions and that when he examined claimant in 1996, he did not believe that claimant was disabled from doing his coal mining job. In 1996, Dr. Malhorta based that decision on claimant's shortness of breath and his pulmonary function study.

The change in Dr. Malhorta's opinion between 1996 and 1999 was based on his objective findings, including the pulmonary function study. The 1999 pulmonary function study showed some mild airway disease and a reduction in claimant's MVV. Dr. Malhorta admitted that the MVV value is effort dependent and a less than optimal effort from claimant would result in a slight reduction in the MVV. Dr. Malhorta has no question that claimant put forth maximum effort on the pulmonary function

study. A reduced MVV level is consistent with obstructive lung diseases, and once the coal workers' pneumoconiosis becomes advanced, it presents as a restrictive disease.

Dr. Malhorta indicated that cigarette smoking can cause small airway disease. However, Dr. Malhorta opined that there is a "very minimal" chance that claimant's cigarette smoking history caused the small airway disease that claimant suffers from. Claimant smoked less than 10 cigarettes per day for 19 years, ending in 1998. Dr. Malhorta stated that this history would indicate that claimant's smoking history probably contributed to claimant's small airway disease, but that he is unable to determine the level of that contribution.

Dr. Malhorta did not conduct an arterial blood gas test, but did look at the results of Dr. Ignacio's arterial blood gas test results. These results showed an increase in oxygenation by claimant. Dr. Malhorta explained that one expects to see a drop in the pO<sub>2</sub> levels in a person with advanced restrictive lung disease. This is not seen in claimant.

Dr. Malhorta also discussed Dr. Fino's pulmonary function studies. Dr. Fino's post-bronchodilation test results exhibited normal results. However, Dr. Fino's pre-bronchodilation test results exhibit abnormal results. The pre-bronchodilation tests show moderate restrictive, moderate obstructive, and a fairly severe degree of small airway disease. Dr. Fino found the pre-bronchodilation test results to be invalid. Dr. Malhorta did not find anything abnormal about claimant's pre- or post-bronchodilation test results.

Claimant's post-bronchodilation test results show no evidence of small airway disease. Claimant's post-bronchodilation results showed improvement, but Dr. Malhorta does not believe that this indicates that claimant's condition is caused by cigarette smoking. Dr. Malhorta stated that both pneumoconiosis and cigarette smoking induced lung disease will show improvement with bronchodilation, however once the disease progresses to a restrictive disease, no improvement will be seen with bronchodilation.

Dr. Malhorta found that claimant's condition deteriorated from 1996 to 1999 to the point where claimant is totally disabled from working as a roof bolter. Dr. Malhorta bases this conclusion on the decrease in claimant's pulmonary function study and claimant's shortness of breath.

*Dr. Gregory Fino*

Dr. Gregory Fino was deposed in this claim on July 26, 2000.<sup>9</sup> (DX 23). Dr. Fino is board certified in internal medicine and pulmonary disease, and is also a certified B-Reader. Dr. Fino's

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<sup>9</sup> The deposition mentions Dr. Fino's report regarding claimant and his curriculum vitae. However, neither of these documents are included in the record.

practice is limited to patients who suffer from various lung problems. Dr. Fino testified that he frequently sees patients with occupationally induced lung disease. Dr. Fino examined claimant on December 2, 1999 to evaluate claimant for occupational lung disease.

Dr. Fino noted that claimant had a 10 year 1/2 pack per day cigarette smoking habit that ended in 1998. Claimant worked 28 years as an underground coal miner ending in 1996. Claimant's last coal mining job was as a roof bolter which Dr. Fino classified as heavy labor. Claimant reported to Dr. Fino that his shortness of breath had worsened over the previous 4 years.

Dr. Fino found claimant's physical examination to be normal. Dr. Fino interpreted a chest x-ray to show 1/1 profusion. Dr. Fino also reviewed two other chest x-rays dated September 30, 1996 and November 12, 1999. Dr. Fino interpreted both of these chest x-rays to show 1/1 profusion. Dr. Fino, therefore, reached the conclusion that claimant suffers from simple pneumoconiosis. Dr. Fino conducted a pulmonary function study that Dr. Fino determined showed good effort after the administration of bronchodilation treatment. This test produced normal results showing neither obstructive nor restrictive impairment. Dr. Fino's lung volume study and diffusing capacity both showed normal results.

Dr. Fino then addressed Dr. Malhorta's pulmonary function study dated November 12, 1999. Dr. Fino found the results to be normal, but found the MVV value to be invalid. Dr. Fino attributed the decrease in the MVV value to poor effort. Dr. Fino found the post-bronchodilation values to be higher because of better effort. Dr. Fino interpreted claimant's FEV1 value to show no ventilatory abnormality. Dr. Fino stated that the parts of Dr. Malhorta's study that were valid confirmed his own findings.

Dr. Fino found that claimant does not suffer from any pulmonary impairment or disability. Dr. Fino bases this conclusion on the objective findings that measure lung function. Dr. Fino concluded that from a pulmonary standpoint, claimant has the ability to perform his last coal mining job considering the objective tests measuring claimant's lung function. Dr. Fino stated that in order for claimant to perform the duties of his last coal mining job, claimant must wear an approved respirator.

Dr. Fino stated that if claimant were exposed to a specified size particle for a prolonged period of time that claimant's condition could progress. However, Dr. Fino determined that claimant's condition is not causing any problem at this point in time. Dr. Fino stated that claimant's arterial blood gas study showed no evidence of small airway disease. Additionally, Dr. Fino stated that pneumoconiosis is not a small airway disease.

### Conclusions of Law

#### *Length of Coal Mine Employment*

Employer has agreed that claimant was a miner within the meaning of the Act for 28 years. (TR 7). I find that this is supported by the evidence of record. Therefore, I find that claimant was a coal miner within the meaning of the Act for 28 years.

#### *Responsible Operator*

Employer has conceded that it is the properly designated responsible operator in this claim. (TR 7). Therefore, I find that P.B.S. Coal, Inc. is the properly designated responsible operator and will provide for the payment of any benefits awarded to claimant.

#### *Existence of Pneumoconiosis*

The regulations provide four methods for finding the existence of pneumoconiosis: chest x-rays, autopsy or biopsy evidence, the presumptions in §§718.304, 718.305 and 728.306, and medical opinions. §718.202(a)(1)-(4). There is no evidence of complicated pneumoconiosis, and claimant is a living miner who filed his claim after January 1, 1982, therefore he is not eligible for the presumptions in §§ 718.304, 718.305, 718.306.

The first method provided for in the regulations to establish the existence of pneumoconiosis is by chest x-ray evidence. 20 C.F.R. § 718.202(a)(1). There are twelve interpretations of five different x-ray films contained in the record as part of claimant's current claim for benefits. Seven of the readings are positive for the existence of pneumoconiosis. Three of these interpretations were rendered by a board certified radiologist and A-Reader, three were rendered by a B-reader, and one was rendered by a board certified internist. The remaining five interpretations are negative for the existence of pneumoconiosis. Four of the negative readings were rendered by dually qualified physicians and one was rendered by a pulmonologist.

A judge is not required to defer to the numerical superiority of x-ray evidence. *Wilt v. Wolverine Mining Co.*, 14 B.L.R. 1-70 (1990). Where two or more x-ray reports are in conflict, the radiological qualifications of the physicians interpreting the x-rays must be considered. (See 20 C.F.R. § 718.202 (a)(1)). Great weight may be given to B-readers due to their expertise. *Aimone v. Morrison Knudson Co.*, 8 B.L.R. 1-689 (1985). The interpretations of dually qualified physicians are entitled to more weight than the interpretations of B-readers. *Herald v. Director, OWCP*, B.R.B. No. 94-2354 BLA (Mar. 23, 1995) (unpublished). Moreover, it is improper to accord greater weight to the interpretations of a physician whose qualifications are unknown. *Stanley v. Director, OWCP*, 7

B.L.R. 1-386 (1984). If the film quality is “poor” or “unreadable,” then the study may be given little weight. *Gober v. Reading Anthracite Co.*, 12 B.L.R. 1-67 (1988).

I accord the most weight to the interpretations of dually qualified physicians contained in the record. I also accord great weight to the interpretations of the B-readers. I accord less weight to the interpretations by physicians who are neither board certified radiologists nor B-Readers. Six positive x-ray interpretations were rendered by a board certified radiologist and an A-Reader and the other six were rendered by a certified B-Reader. I find this evidence more overwhelming than the four negative interpretations rendered by dually qualified physicians. Accordingly, I find that claimant has established the existence of pneumoconiosis by a preponderance of the x-ray evidence.

Claimant has failed to establish the existence of pneumoconiosis by the second and third methods because there is no biopsy evidence and he is a living miner who filed a claim after 1982 without evidence of complicated pneumoconiosis. 20 C.F.R. §§ 718.202(a)(2) and (a)(3).

The fourth method available to claimant to establish the existence of pneumoconiosis is by a reasoned medical opinion from a physician establishing that claimant suffers from a respiratory or pulmonary impairment arising out of coal mine employment or by meeting the definition of pneumoconiosis provided at 20 C.F.R. § 718.201. 20 C.F.R. § 718.202(a)(4). Section 718.201 defines pneumoconiosis as a “chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment...[a] disease ‘arising out of coal mine employment’ includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.” Legal pneumoconiosis is defined by § 718.201(a)(2) as including “but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.”

Opinions from four physicians appear as part of the record in this claim. Drs. Malhorta and Fino found the existence of pneumoconiosis based on the miner’s occupational history and chest x-ray evidence. Drs. Antwerp and Patti found that claimant does not suffer from any occupationally induced pulmonary impairment. I find the opinions of Drs. Malhorta and Fino to be better reasoned and better based on the objective medical evidence. Dr. Antwerp offers minimal reasoning for his finding of no pneumoconiosis. Dr. Patti’s opinion is very well reasoned, however, I find it outweighed by the well reasoned opinions of Drs. Malhorta and Fino based on the objective medical evidence. Therefore, I find that claimant has established the existence of pneumoconiosis based on the physician opinions evidence contained in the record.

Weighing all of the evidence together, I find that claimant has established the existence of pneumoconiosis in accordance with the applicable regulations. An administrative law judge must weigh all evidence together under 20 C.F.R. § 718.202(a) to determine whether the miner suffers from pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4<sup>th</sup> Cir. 2000); *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22 (3<sup>rd</sup> Cir. 1997). The x-ray evidence in this claim

establishes the existence of pneumoconiosis by a preponderance of the evidence. There is no biopsy or autopsy evidence, and the presumptions of §§ 718.304, 718.305, and 718.306 are inapplicable. Claimant has established pneumoconiosis by a preponderance of the physician opinion evidence.

Therefore, I find that claimant has established the existence of pneumoconiosis pursuant to 20 C.F.R. §718.202(a)(1)-(4).

### *Arising Out of Coal Mine Employment*

In order to receive benefits, the claimant must show that his pneumoconiosis arose out of his coal mine employment. As claimant has twenty-eight (28) years of coal mine employment, he is entitled to the rebuttable presumption at § 718.203(b) that his pneumoconiosis arose out of his coal mine employment. Because the employer has failed to offer evidence sufficient to rebut the presumption, I find that claimant's pneumoconiosis arose out of his coal mine employment.

### *Total Disability*

Total disability is defined as pneumoconiosis which prevents or prevented a miner from performing his usual coal mine employment or other gainful work. §§ 718.305(c), 718.204(b)(2). Section 718.204 sets out the standards for determining total disability.

Total disability may be established by pulmonary function testing. 20 C.F.R. § 718.204 (b)(2)(i). Little or no weight may be accorded to that pulmonary function study were the miner exhibited poor cooperation or comprehension. *Houchin v. Old Ben Coal Co.*, 6 B.L.R. 1-1141 (1984); *Runco v. Director, OWCP*, 6 B.L.R. 1-945 (1984); *Justice v. Jewell Ridge Coal Co.*, 3 B.L.R. 1-547 (1981). If fair effort is noted on the study, however, the study may be conforming. *Laird v. Freeman United Coal Co.*, 6 B.L.R. 1-883 (1984); *Verdi v. Price River Coal Co.*, 6 B.L.R. 1-1067 (1984); *Whitaker v. Director, OWCP*, 6 B.L.R. 1-983 (1984). Neither of the pulmonary function studies contained in the record in this claim produce qualifying values. Therefore, I find that the claimant has failed to establish by a preponderance of the pulmonary function test evidence that he is totally disabled under the provisions of (b)(2)(i).

The claimant can also establish total disability with qualifying arterial blood gas testing that meets the regulation standards. 20 C.F.R. § 718.204(b)(2)(ii). There is only one arterial blood gas study included in the record in this claim. This study does not produce qualifying results. Based on these test results, I find that the claimant has failed to establish total disability pursuant to 20 C.F.R. § 718.204 (b)(2)(ii).

There is no evidence that the claimant suffers from cor pulmonale with right-sided congestive heart failure. Therefore, total disability is not established under 20 C.F.R. § 718.204(b)(2)(iii). Total disability may also be established if a physician exercising reasoned medical judgment, based on

medically acceptable clinical and laboratory diagnostic techniques, concluded that the claimant's respiratory or pulmonary impairment prevents him from engaging in his usual coal mine work or in comparable and gainful employment. In assessing total disability under § 718.204(b)(2)(iv), a judge is required to compare the exertional requirements of the claimant's usual coal mine employment with a

physician's assessment of the claimant's respiratory impairment. *Schetroma v. Director, OWCP*, 18 B.L.R. 1-19 (1993).

Dr. Antwerp does not address whether claimant is disabled because Dr. Antwerp did not find the existence of pneumoconiosis. Therefore, Dr. Antwerp's opinion will be discussed no further. Dr. Malhorta found that claimant is totally disabled due to pneumoconiosis based on claimant's symptom of shortness of breath and the objective testing. Drs. Fino and Patti found that claimant is not totally disabled based on the objective testing. Dr. Fino found that claimant is able to perform his last coal mine employment provided that he use a respirator while working. Dr. Patti found that claimant's symptoms are caused by obesity and that all of claimant's tests measuring pulmonary function produced normal results. Dr. Patti also found that from a pulmonary standpoint, claimant is able to return to his last coal mining job.

I find the opinions of Drs. Fino and Patti to be better reasoned and based on the objective medical evidence contained in the record. Therefore, I find that claimant has failed to establish that he is totally disabled due to pneumoconiosis. Accordingly, the etiology of total disability is not necessary to discuss considering that no total disability has been found.

#### *Entitlement*

Upon consideration of all of the evidence of record, I find that claimant has failed to meet his burden of proof on all elements of entitlement under the Act and is therefore not eligible for benefits.

#### *Attorney's Fees*

The award of an attorney's fee under the Act is permitted only in cases in which claimant is found to be entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to claimant for services rendered to him in pursuit of this claim.

### **ORDER**

It is hereby ordered that the claim of Dale K. Miller for benefits under the Black Lung Benefits Act is hereby DENIED.

A

ROBERT J. LESNICK

Administrative Law Judge

NOTICE OF APPEAL RIGHT: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date of this Decision and Order by filing notice of appeal with the ***Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601.*** A copy of notice of appeal must also be served on *Donald S. Shire, Esq., Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.*